First Steps

INDIANA'S INDIVIDUALIZED FAMILY SERVICE PLAN

TO ENHANCE THE CAPACITY OF FAMILIES TO MEET THE SPECIAL NEEDS OF THEIR CHILD

IFSP: Interim (Date) _____ Initial (Date)_____ Annual (Effective Date)_____

***SECTION 1*: IDENTIFICATION INFORMATION**

IFSP-State Form 46514(R6/11-02)/BCD0001

*Child's name _____ A.K.A Name : _____
Last Name *First Name* *MI*

**SS#_____*DOB _____ *Chronological/Adjusted Age _____/_____*Gender:____

*First Steps Identification Number _____

Benefit Status:(✓ all that apply)

Hoosier Healthwise: ___ Yes ___ Pending, CSHCS ___ Yes ___ Pending, Waiver Program ___ Yes ___Pending
SSI ___ Yes ___ Pending, Private Insurance ___Yes ___ Pending,

*Circle one: PARENT / GUARDIAN / FOSTER PARENT / SURROGATE PARENT

*Name(s) _____

*Address _____

*City _____, IN *Zip Code _____ *County _____

*Phone day (w____ h____) _____ eve (w____ h____) _____ e-mail: _____.

Best time to call _____ Family's Primary Language / Mode of Communication: _____

*Child's Primary Language / Mode of Communication: _____

*Circle one: PARENT / GUARDIAN / FOSTER PARENT / SURROGATE PARENT

*Name(s) _____.

*Address _____

*City _____, IN *Zip Code_____ *County _____

*Phone (day) (w___ h___) _____ (eve) (w___ h___) _____ e-mail :_____

Best time to call _____ Family's Primary Language / Mode of Communication:_____

***SECTION 2*: SERVICE COORDINATION INFORMATION**

***Service Coordinator** Name / Agency: _____

*Telephone(s): _____*Fax:_____ e-mail: _____

*Address: _____

*City: _____ IN *Zip Code_____

Intake Coordinator's Name: _____ Telephone: _____

Fax: _____ E-mail: _____.

Address:_____

*City_____ IN * Zip Code _____

* Denotes part of the electronic record

** Your child's social security number is requested in order to expedite processing this IFSP. Disclosure is voluntary and you will not be penalized for refusal per I.C. 4-1-8-1.

Child's Name: _____ **DOB:** _____ **IFSP Date:** _____

SECTION 3: SUMMARY OF CHILD'S PRESENT LEVEL OF PERFORMANCE & EVALUATION INFORMATION

Please document the requested information below. All information should relate to the developmental needs of the child and family and should be gathered from discussion with the family.

Child's Strengths:	**Family's Strengths:**
Concerns/needs related to the child's development:	**Medical Diagnosis:** **ICD 9 Code:** **Health:** **Other:**
Screening Results: **Vision:** ❑ Passed ❑ Concerns Comments _____ **Hearing** : ❑ Passed ❑ Concerns Comments_____	

Please document information relating to the child's development. Information may be gleaned from assessments, structured observation or other methods. ***Parent report must be utilized.*** *The statement about the child's present level of performance must be based on professionally acceptable objective criteria. This information is then to be utilized in the determination of eligibility.*

Domain (Person/Date)	**Assessment Procedures** Please check all procedures used	**Statement of child's current level of performance** ☐ Child in NICU Describe the child's current level of performance. In addition, provide age scores *OR* percent delay. Check if services are recommended.
Cognition ___/___/___	☐ Structured Observation ☐ State approved assess.* ☐ Other Assessment ☐ Parent Report (Required)	Developmental age _____ *OR* Percent Delay _____ Services Recommended: ☐ Yes ☐ No
Physical ** Development ___/___/___	☐ Structured Observation ☐ State approved assess.* ☐ Other Assessment ☐ Parent Report (Required)	Developmental age _____ *OR* Percent Delay _____ Services Recommended: ☐ Yes ☐ No
Communi- Cation ___/___/___	☐ Structured Observation ☐ State approved assess.* ☐ Other Assessment ☐ Parent Report (Required)	Developmental age _____ *OR* Percent Delay _____ Services Recommended: ☐ Yes ☐ No
Social/ Emotional ___/___/___	☐ Structured Observation ☐ State approved assess.* ☐ Other Assessment ☐ Parent Report (Required)	Developmental age _____ *OR* Percent Delay _____ Services Recommended: ☐ Yes ☐ No
Adaptive ___/___/___	☐ Structured Observation ☐ State approved assess.* ☐ Other Assessment ☐ Parent Report (Required)	Developmental age _____ *OR* Percent Delay _____ Services Recommended: ☐ Yes ☐ No

* State Approved Assessments: Developmental Programming for Infants and Young Children, Hawaii Early Learning Profile, The Carolina Curriculum for Infants and Toddlers with Special Needs, 2nd ed., and the Assessment, Evaluation, and Programming System for Infants and Children

** Physical Development is defined as motor skills, vision and hearing.

Child's Name _____ **DOB** _____ **IFSP Date** _____

SECTION 4*: OUTCOMES** ***(This page should be duplicated, as needed, one outcome per page.) ***Outcome #*** _____

The IFSP must include the major outcomes expected to be achieved for the child and family, and the criteria, procedures, and timelines used to determine the achievement of the outcome. Outcomes should be written in a language that is easily understood by the family all IFSP Team members, and should not include specific services or individual names until the IFSP is completed and all Outcomes reviewed and discussed in total with the family. At that time, circle the type of service or provider that is mutually selected to be the most appropriate to assist the family in addressing each strategy or activity.

Outcome Statement: what we would like to see happen for our child/family:	What we see now:
	What will be different:

Strategies for working on this outcome utilizing the daily routines and activities of our child and family.	Brainstorm people who / resources that can help. CIRCLE final selection.

Refer to Section 5, Natural Settings/Environments and Section 2 on the Family Interview to be sure that the considerations and selection of sites of service, including the physical setting as well as the service approach or environment* is incorporated into this Outcome. If a service in a particular setting, or service approach is not available and alternative options are being implemented, insert a strategy or activity that defines the activities of the Service Coordinator, family and other IFSP team members directed at resource development, etc. to fully implement this Outcome. *(i.e., family directed, child directed in individual services or group activities, etc.)

Child's Name _____ **DOB** _____ **IFSP Date** _____

***SECTION 5*: NATURAL SETTINGS / ENVIRONMENTS**

Federal statute requires that early intervention services be provided in natural environments and may only be provided in other settings when services cannot be achieved satisfactorily in the natural environment. Please complete the following section. If Section 2 of the Family Interview form has bee completed within the past 30 days, it is not necessary to complete this section of the IFSP, as the Family Interview information may be utilized.

*Please **circle** the following people are involved in your child's care and check those you would like included in your child's services:*

	Please involve
Mother	ð
Father	ð
Step Parents	ð
Foster Parents	ð
Grandparents	ð
Other caregiver	ð
Childcare provider	ð

My child is able to complete the following routines successfully and independently:

	Yes	With Help	I would like FS to help
• Get up in the morning	ð	ð	ð
• Dressing	ð	ð	ð
• Meal time	ð	ð	ð
• Inside play	ð	ð	ð
• Outside play	ð	ð	ð
• Getting along with peers	ð	ð	ð
• Family games	ð	ð	ð
• Nap time	ð	ð	ð
• Toileting time	ð	ð	ð
• Going to bed	ð	ð	ð
• Leaving home	ð	ð	ð
• Other:	ð	ð	ð

In the past 2 weeks my child has participated in the following community settings: Please note if there have been any concerns with access to these settings.

- ð Grocery shopping
- ð Other shopping
- ð Visiting friends/relatives
- ð Going out to eat
- ð Attending social activities
- ð Attending a religious service
- ð Childcare
- ð Headstart
- ð Community children's activities
- ð Community event
- ð Other

Once services are written into the IFSP, this section must be completed for any service that will not be provided in the Natural Environment of the child. Discussion must include why the service will be more appropriately provided in this setting, what barriers exist for the provision of service in the natural environment and how the services will be generalized for incorporation into daily routines and activities. For clarification purposes, "setting" refers to the physical place where services will be provided and "environment" refers to the approach to be used in providing services, which may include parent-directed services, individual child-focused services, or services provided within a group.

1. What barriers prohibit the provision of services in the child/ family/s daily routines and activities?

2. How will this barrier be addressed in the chosen location of service?

3. What will need to change in order for this service to be provided within the family's routine?

4. How will this need be accomplished / addressed by the team?

Child's Name _____ **DOB** _____ **IFSP DATE** _____

Date (if an addendum page) _____

SECTION 6*: TRANSITION CHECKLIST / OUTCOME** ***(Duplicate as needed) **Outcome #** _____

The IFSP must include the steps to be taken to support the transition of the child into, within and from the First Steps early intervention system. This section may be completed during a routine review or evaluation of the IFSP, or at other times as appropriate. *This includes activities designed to ensure a smooth transition from the hospital to home, the selection of service providers, transition between center-based services to home, the addition or reduction of services, or the transition to services at age 3 OR when the child is no longer eligible. Transition activities include discussions with, and training of, parents regarding future placements, procedures to prepare the child, family and service providers for these changes. With parental consent, information about the child is shared with receiving providers to ensure continuity of services and assist in planning. Transition needs should be expanded in a specific Outcome within the IFSP and will provide more specificity/detail.*

<table>
<tr><td>Transition Activities into the First Steps program:</td><td>Projected Date</td><td colspan="2" rowspan="2">Outcome: (Relating to the Transition Issue)</td></tr>
<tr><td>Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services</td><td></td></tr>
<tr><td>Transition Activities within the First Steps program</td><td></td><td colspan="2" rowspan="2">From : To:

Concerns relating to transition:</td></tr>
<tr><td>Family changes that may affect IFSP service delivery (i.e., employment, birth or adoption of sibling, medical needs of other family members)</td><td></td></tr>
<tr><td>Child changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)</td><td></td><td colspan="2" rowspan="5">We will accomplish this Outcome with the following strategies/activities including timelines in which they are to occur:

Brainstorm people/resources that can help. Circle final selection(s):</td></tr>
<tr><td>Introduction of new or a change in Service Provider(s)</td><td></td></tr>
<tr><td>Termination of existing IFSP services</td><td></td></tr>
<tr><td>Transition Activities out of the First Steps program</td><td></td></tr>
<tr><td>Exiting the First Steps system:
Date(s)
_____Contact CSHCS Customer Service/Prior Authorization Unit (if applicable) to explore future service options.
_____Explore community program options for our child
_____Explore community program options for our family
_____Discuss transition process and our rights and responsibilities under Part C
_____Send specific information to the local education agency, with our informed, written consent, at our child's age 18 months
_____Send specific information to the local education agency, with our informed, written consent, at our child's age 30 months
_____Send specified information to community programs, upon our informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system
_____Convene the 90 day transition meeting
_____Other</td><td></td></tr>
</table>

Child's Name _____ **DOB** _____ **IFSP Date:**_____

SECTION 7: EARLY INTERVENTION SERVICES

This entire page is part of the electronic record. Early intervention services must meet the developmental needs of the child and the needs of the family related to enhancing the child's development, and are based upon the Outcomes developed. Services are selected in collaboration with the parents and provided under public supervision by qualified personnel in conformity with the IFSP. Unless otherwise indicated, the early intervention services listed below are funded through the Central Reimbursement Office. Any service that is to be provided in a setting other than the natural environment of the child must be documented in Section 7a of the IFSP.

Early Intervention Services Options			Location
Assistive Technology Audiological Services Health Services Medical Diagnostic Services	Nursing Services Nutrition Services Occupational Therapy Physical Therapy Psychological Services	Social Work Services Special Instruction Speech/Language Therapy Transportation Vision Services	1. Program designed for children w/ delays/disabilities 2. Program designed for typically developing children 3. Home 4. Hospital (Inpatient) 5. Residential Facility 6. Service Provider Location 7. Other Setting

Services	Related outcome	**Frequency and Intensity of Service**	**Start Date**	**End Date**	**Location Code**	**✓ If On-site**	**Providers Information Name and Agency**
Service Coordination	ALL	Billing 1/month					

THE CONTENTS OF THIS COMPLETED IFSP HAVE BEEN FULLY EXPLAINED TO ME / US. I / WE GIVE INFORMED, WRITTEN CONSENT TO IMPLEMENT THE SERVICES DESCRIBED IN THIS SECTION OF THE IFSP. I / WE HAVE RECEIVED A WRITTEN COPY OF PARENT RIGHTS, OPPORTUNITIES AND RESPONSIBILITIES WITHIN THE FIRST STEPS EARLY INTERVENTION SYSTEM, AND THE INTAKE / SERVICE COORDINATOR HAS EXPLAINED THIS INFORMATION VERBALLY AS WELL.

_____ _____

Parent / Guardian / Surrogate Parent Signature Date Parent / Guardian / Surrogate Parent Signature Date

SECTION 8: OTHER SERVICES

*To the extent appropriate, the IFSP must include services that are **not required or covered** under Part C. Listing the non-required services does not mean that those services must be provided; however, their identification can be comprehensive and helpful to both the family and the service coordinator and provide ways to attempt to secure those services. Services must correspond to family identified outcomes listed in Sections 4 and 6 .*

Service	**Start Date mo/day/yr**	**Duration (months)**	**Provider Information**	**Fund Source**

BASED ON THE ATTACHED SUMMARY OF THE CHILD'S PRESENT LEVEL OF PERFORMANCE AND EVALUATION INFORMATION, I AGREE THAT THE RECOMMENDED THERAPIES ARE NECESSARY AND APPROPRIATE.

Physician Name (Printed): _____ Phone: _____Fax:_____

Physician Signature: _____ Date: _____

Please return the signed copy of this page to the child's Service Coordinator, _____ at,

Phone: _____ Fax: _____

If you have additional questions relating to the eligibility or evaluation information for this child, you may contact the Eligibility Team (ED): _____ _____ _____

Contact Name Phone Fax

Child's Name _____ **DOB** _____ **IFSP Date**_____

SECTION 9: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

*IFSP meetings **must include** the parent(s), other family members as requested by the parent, an advocate or person outside the family as requested by the parent, the service coordinator, person(s) directly involved in conducting the evaluations and assessments, and as appropriate, persons who will be providing services to the child or family.*

I FSF	Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation
		PARENT			
		PARENT			
		Intake Coord.			
		ED Team Rep			
		ED Team Rep			
		Service Coord.			

A copy this IFSP will be sent to the providers listed in Section 7 and those persons indicated above (✓ IFSP column accordingly). In addition, the IFSP will be sent to the following individuals:

ED TEAM CONTACT PERSON: _____ **Phone:**_____

ED team Contact person mailing address

NAME: _____ **NAME:**_____

IFSP MEETING MINUTES: Written documentation of the IFSP meeting must be recorded. Notes should document general discussion, any unresolved issues, and follow-up activities. (Attach additional pages as needed)

Name and Role of person taking minutes: _____

Location of meeting: _____ Start time of meeting: _____ End time:_____

Meeting participants are to be listed above. If any participants did not stay for the full meeting, please indicate person and time they were present:

Name :	Time of participation:
Name:	Time of participation:

NOTES:

*Note Taker Signature:*_____

Child's Name _____ *DOB* _____ *County* _____

SECTION 10: OUTCOME REVIEW

IFSP DATE:_____

OUTCOME REVIEW (This page should be duplicated as needed, per review) Review cycle : 6 months_____other(explain)_____

A review of the IFSP must be conducted at least every six months or if the family requests a review, to determine the degree of progress toward achieving outcomes and whether modification or revision of the outcomes or services is necessary. ***Advance, written notice about meetings must be given to parents and other participants.***

Out-come #	Progress Summary	Justification (Please attach the written recommendations from the team and any supporting documentation.)

Modifications: As listed below the following modifications are being recommended by the team.

Use + to Add or – to Term.	Modification in Service(s)	RELATED TO OUTCOMES	Freq/Intensity (times per WK or MO/mins per time)	Anticipated Start Date	End Date	✓ If on-site	LOCATION CODE	Provider Information (INCLUDE PROVIDER NAME AND PAYEE)

I/We participated in the IFSP review process and agree with the revisions reflected in this section. I understand that changes in service that result in a modification to the service, such as an addition or increase of a service, or changing the location of a service to an on-site location, requires the consent of my child's physician and the IFSP and Eligibility Determination team. Once signed by my child's physician, I/we give informed, written consent to implement the services described in this document. A copy of this completed modification page will be distributed to appropriate members of our IFSP team. I/We have received a copy of parent rights for the First Steps Early Intervention System and had these rights explained verbally by our Service Coordinator.

_____ _____ _____ _____

Parent / Guardian / Foster Parent / Surrogate Parent Signature (required) Date (Other) Parent Signature Date

_____ _____ _____

ED Team representative Signature (required) Date Phone

_____ (_____)_____ (_____)_____

Service Coordinator Signature (required) Date Phone # Fax#

_____

Service Coordinator Address

PHYSICIAN: _____

Listed below are the services that the child is expected to receive once the modifications are approved:

RELATED Outcome	Service	Intensity/Frequency	Anticipated Start Date	End Date	On site ✓	Provider name and Agency

Once you have reviewed the above modifications to the IFSP, please indicate your agreement with the services planned for this child and family in the space provided. Please return this signed form to the service coordinator listed above and retain a copy with the IFSP document in your patient records. If for any reason you do not agree with the services set forth in the IFSP, please contact the service coordinator immediately to discuss your concerns. You may also attach comments to this form.

_____ _____

Physician Signature Date

Child's Name: _____ **D.O.B.**_____ **IFSP date:**_____

Service Coordination Worksheet

Service Coordinator Role: To provide service coordination services that assist and enable an infant or toddler and the child's family to receive the services, rights and procedural safeguards authorized to be provided under the early intervention program. Service coordination involves assisting parents in gaining access to early intervention services, coordinating the provision of early intervention services and other services the child needs, facilitating parent to parent support services, facilitating the timely delivery of available services, and continuously seeking the appropriate services and situation necessary to benefit the development of the child for the duration of the child's eligibility.

Responsibilities:

- Facilitate & Participate in the development, review, and evaluation of the IFSP:
  - ✓ 6 month review of the IFSP with the family: Projected DATE: _____
  - ✓ OTHER Planned review: Projected DATE: _____
- Facilitate evaluation activities related to the annual evaluation of eligibility and IFSP development: Projected DATE: _____
- Assist families in identifying available services, including parent-to-parent support Projected DATE: _____
- Coordinate and monitor the delivery of available services, including assistance in identification of access to available sources of financial support for these early intervention services, including Hoosier Healthwise and CSHCS, and Financial Case Management Services to assist in determining benefits through private insurance:
  - ✓ Provide Financial Case Management
  - ( ) Facilitate application for Hoosier Healthwise
  - ( ) Facilitate application for Children's Special Health Care Services (CSHCS)
  - ( ) Assist n facilitating an application for Medicaid Waiver program(s) _____
  - ( ) Facilitate referrals to other program(s): NAME(S) _____
- Inform families of the availability of advocacy services:
- Obtain consents / release of information forms as needed:
- Facilitate the development of a transition plan into, within, and from the early intervention system, including transition to Part B special education, pre-school services or other community services as appropriate at age three or when the child is no longer in need of or eligible for early intervention services:
  Projected DATE:_____
- Coordinate requests for Assistive Technology devices as needed:
- Other: _____

Communication techniques and guidelines to assist in the coordination of services:

- Facilitate communication with the IFSP team:
  Method: _____

  _____

  Frequency: _____

  Other persons (including care givers) that should be included in team communications:
  Name: _____ For the purpose of: _____

  Frequency / Timelines: _____
- Conduct personal meetings with the family: Frequency: _____
- Maintain the early intervention file at the System Point of Entry
- Coordinate receipt of quarterly provider reports: Dates due: _____
- Coordinate with medical and health providers
- Coordinate communication with the child's primary medical home